

Missouri Department of Mental Health Office of Deaf Services Interpreter Exchange Program Application

Name					Date of Birth		
Address City		State Zip Code		e Phone Number			
Email Address			Agency/Er	mployer			
Highest Education Completed:	☐ Associate's	☐ Bachelor's	☐ Mas	ter's	□ Speciali	st 🗆 Doctora	te
MO-BEI Certification: ☐ Basic	☐ Advanced	☐ Master	☐ Other:			□ None	
RID Certification: NIC NIC	IC Advanced	☐ NIC Master	□ CI	□ CDI	□ Othe	r:	□ None
ease answer the following questi	ions thoroughly.	. Attach addit	tional pag	es if nee	ded.		
. What experience do you have	in interpreting in	n the mental	health fie	ld?			
. What training have you receive	ed in mental hea	alth interpreti	ng?				
. Why do you want to participat	e in the Interpre	eter Exchange	Program	?			
, ,				•			
. How do you plan to use this tr	aining in the futu	ure?					
Applicant Signature:				Date: _			
		For DMH Use	Only				
proved: Yes No Date to complete h	ours:		Da	ate hours co	mpleted: _		
S Director Signature:		DBH Dep	outy Director	Signature:			